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Community mental health: a brief, global perspective

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Abstract

There is increasing realization of the magnitude of the disease burden attributable to mental, neurological and substance use disorders globally. This impact is disproportionately distributed, with slightly more than two thirds of this burden being situated within low and middle income countries. Furthermore, in both developed and developing countries, a significant treatment gap exists, but is greater in developing countries. Disparities in available financial and human resources for the provision of mental health services also exist, both across and within countries and regions of the world.

Despite these evidence, and the calls for urgent reform of mental health services globally, several key barriers continue to hinder progress. These include reduced access to services, inequalities in resource distribution, and stigma and discrimination. A 'balanced model of care' that takes into cognizance, the available resources and context; advances a task sharing approach and recommends the increased utilization of community mental health services, is a pragmatic approach that can help to surmount these barriers. Additional drivers of change, that can enhance the implementation of this approach are also presented and discussed.

Key words: community mental health, task sharing, treatment gap

1. Background

Global attention to mental health issues is slowly but steadily gaining traction across the world, as a culmination of a series of important historical steps. The global burden of disease study, which utilized the composite measure of disability adjusted life years to rank all diseases and injuries was an important first step; which brought to the fore, the significant burden accruing from mental, neurological and substance use (MNS) disorders [1]. The World Health Organization (WHO) responded to these emerging facts with a renewed focus on mental health, as reflected in the theme of its world health report of 2001 titled “*mental health: new understanding, new hope*” [2]. Additional impetus was generated from the collaborative efforts by global mental health experts, which led to a series of powerful, evidence-based advocacy papers since 2007 [3 - 9].

Furthermore, the WHO’s world mental health surveys clearly highlighted that the majority of people with serious mental disorders were not accessing any treatment [10]. Consequently, the WHO launched the Mental Health Gap Action Programme (mhGAP) in 2008, as well as the intervention guide (mhGAP-IG) manual to counter this treatment gap [11,12]. The United Nations has also lent itself to the mental health cause with the launching of the WHO Mental Health Action Plan 2013 – 2020 [13].

There is clear evidence to recommend that mental health interventions are best delivered in the community; or should be available within close proximity of the where people live. Community mental health services aims to prioritize the treatment as well as rehabilitation of individuals with mental disorders, and to improve their capacity to live and function optimally within their communities, without disrupting their fulfilment of major life obligations such as to family, friends, neighbours and work. [14].

However, despite these sustained efforts over the last two decades to ensure that mental health is accorded priority attention, several hurdles have endured and continue to hinder the attainment of the provision of affordable, accessible and evidence-based, qualitative mental health care services for people in need, across the world. This article presents some of these challenges, as well as the rationale for rethinking the organization of mental health care services and a shift towards community mental health services.

2. What are the challenges?

A combination of several factors continue to hold back the progress of mental health reforms across the world, despite clear and available evidence. These factors act independently and in tandem, to reduce access to qualitative mental health care services, and they include:

2.1. *Treatment gap*

The world mental health surveys revealed that more than two thirds of people with serious mental illnesses across the world do not receive any care at all. This treatment gap is highest in low and middle income countries (LMICs) where nine out of ten people with serious mental disorders may not have accessed any care whatsoever, in the preceding year [15]. Additionally, reports also clearly show that treatment coverage for physical disorders is much better than those for mental illnesses in both developed and developing countries [16].

2.2 *Reduced life expectancy*

Individuals with mental illnesses suffer reduced life expectancy and die earlier than their counterparts without mental illness in a given environment [17-19]. The long held myth that mental disorders do not cause mortality is therefore, incorrect. Putative mechanisms underpinning this observed disparities include the high medical co-morbidities associated with mental illness and its treatment, as well as the poorer access to general health care services for physical disorders such as heart diseases [18].

2.3. *Inequalities in the distribution of mental health resources*

The burden of MNS disorders, as well as the human and financial resources required to address these burdens are not equitably distributed across the world. It is estimated that about 70% of the global burden of MNS disorders occur in LAMICs while high income countries enjoy about 90% of the global mental health resources [20]. Furthermore, the United States of America, a high income country; has more psychiatrists than the two

most populous nations of the world, China and India; as well as all the countries of the African continent combined together [7]. Intra-country disparities also occur, with the majority of the mental health resources usually concentrated in the large cities and often times, in a particular region of a given country [21]. Superimposed on the insufficient numbers of available mental health professionals is the consistent loss of skilled manpower from developing countries to high income countries [22]. These practical realities ultimately culminate in reduced access to mental health services for the larger proportion of those in need.

2.4. *Stigma and discrimination*

Widespread stigma and discrimination of people with mental illness is still rife, with associated occurrence of human rights abuses. About 8 in 10 people with depression had experienced discrimination - usually within familiar settings such as with family members, friends, work relationships, marriage and divorce and with other interpersonal relationships [23, 24]. Even more importantly, nearly forty percent of people with depression will not reach out for things they truly consider important in their personal and work life, out of fear (anticipated stigma) that they may be discriminated against [23]. This hinders progress, as the tendency is to hide family members with mental illness out of embarrassment, rather than bring them forward to access the treatment and care they need. Such individuals are thus, often at increased risk of suffering human rights abuses. Similar findings have also been reported for people with schizophrenia [25].

3. the 'balanced care model' of mental health services

It is a truism that effective mental health care services can neither be delivered exclusively within the hospital setting, nor can this be achieved exclusively within the community. Some individuals may experience very serious mental disorders that will necessitate in-patient hospital care; while some others will still be able to function within the community, albeit with some challenges, on account of less serious symptoms. It is therefore pragmatic to consider options for integrating the different components of

mental health care services that will best suit the requirements of a specified region or country – based on availability of resources, cultural, political and other environmental considerations. The balanced care model recommends the organization of mental health care services that ensures an optimal mix of hospital based services, as well as community based services [26, 27]. However, it is not a one size fits all approach, but one that is guided by research evidence as well as the availability of resources in a given context. It specifies three tiers of possible combinations of mental health services, based on available resources as outlined in Figure 1.

(Figure 1 about here)

It is important to give due consideration to the specific needs of children and adolescents in the organization and allocation of services, as they constitute nearly half of the populations in developing countries [28]. Additionally, nearly half of all adult mental disorders have their onset before age 14 years, and it is therefore a sensible investment to aim for early detection and provision of interventions in order to reduce the future burden [29].

3.1. Task sharing

Task sharing is a process that ensures the transfer of specific task from highly qualified specialists to other health workers with less expertise (or qualifications) in a specified area of competence – in this case, mental illnesses [30]. It is an effective strategy for the implementation of the balanced care model, especially in low resource settings. Successful examples of programmes utilizing task sharing for scaling up mental health services from Chile and India [31, 32].

In India, the MANAS trial utilized a stepped care approach to task sharing and clearly demonstrated the effectiveness of using lay counsellors to identify and treat common mental disorders in primary care [32]. However, some criticism has been levelled against the calls to integrate mental health into primary care, as well as the advocacy efforts to reduce the treatment gap across the world. These criticism revolve largely around the

expressed fear that such calls may result in the imposition of a narrow biomedical paradigm, or focus exclusively on integration into primary care without adequate attention to other components of service delivery such as community rehabilitation and culturally appropriate psycho-social interventions [33, 34]. However, these concerns are adequately taken into consideration by the balanced care model and task sharing strategies, which are premised on the optimal utilization of the best matrix of services, mixed according to the available resources to suit the needs of any given context, with a strong emphasis upon the provision of psycho-social interventions and support to family members and carers [34].

4. Available resources and drivers of change

Several useful resources are currently available to provide guidance for the development and implementation of a balanced model of care for the provision of mental health services. Some of these developments and resources include the World Psychiatric Association (WPA) guidance series on developing community mental health services from different regions of the world [35 – 38], the mhGAP-IG of the WHO [8], and the Fundamental Sustainable Development Group (www.FundamentalSDG.org).

4.1 WPA Guidance series

The WPA guidance series were commissioned to detail the experiences and state of the evidence gained from several attempts to develop and implement community mental health services in various regions and continents of the world. It is a rich source of cumulative experience and a practical demonstration of the lessons learnt, mistakes to avoid and challenges to be anticipated [35 – 38].

4.2. World Health Organization's mhGAP-IG Manual

This manual was developed through a rigorous and intensive process involving hundreds of global experts to identify priority MNS conditions with a high disease burden, huge

economic costs and availability of effective treatment interventions. The manual consists of simple and practical guidelines for training non-specialists to identify and deliver treatment interventions for priority conditions and to refer more serious cases for specialist care [8]. It has been adapted and pilot implemented in some countries such as Nigeria, with good results [39].

4.3 Fundamental SDG

This is a global coalition of passionate advocates to ensure the inclusion and strengthening of mental health in the post - 2015 development agenda [40]. The website has several useful reference materials and evidence based advocacy materials that can be useful for those interested in developing and implementing community mental health services. Advocacy materials and research evidence are particularly useful to provide a compelling case for policymakers and stakeholders to see the need for a balanced model of mental health care services provision.

5. Conclusion

A compelling need for the re-organization of mental health services exists and borders on ethical principles of equity, justice and freedom from discrimination. There is strong evidence as well as tools to guide the development and implementation of community mental health services in various regions of the world. Indeed the WHO 2014 World Mental Health Atlas shows reasonably rapid trends in several countries to change from a pattern of psychiatric beds in psychiatric hospitals to those within acute general hospitals (41). We therefore recommend the greater adoption of community mental health services, organized using a balanced care model, as a pragmatic and feasible option for scaling up mental health care services across the world.

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